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The Regional Medical Program in California

Its Changing Nature

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IN THE EARLY PART of its fifth year of funded support, the California Regional Medical Program (CRMP) is continuing to evolve, to assess its progress, its objectives and its manner of carrying out the philosophy and intent of the legislation authorizing what is in many ways an unusual federal program. Along the way there has been praise for the accomplishments of the California program, due in great part to the strong support in this state from both professionals and laymen in medicine and health; and there have been disappointments.

Changes in program direction have not been limited to California, but have been accelerated by the national Administration's recent adoption of priorities for health and a consequent desire to pursue these enunciated health goals through existing health programs.

The Guidelines for the original legislation establishing regional medical programs (Public Law 89-239) described a major purpose of RMP as a "creative partnership" among practicing physicians, hospitals, medical schools, nurses, public and voluntary health agencies and other health resources. New "cooperative arrangements" in the partnership would help to bring new knowledge more rapidly to the patient's

bedside, no matter where he lived. The attempt was to be made to bring high quality medical care more quickly to every American citizen. As the Guidelines put it, the program was "intended to provide a means for conveying to the medical institutions and professions of the nation the latest advances in medical science for diagnosis, treatment and rehabilitation of patients afflicted with heart disease, cancer, stroke or related diseases." Although preventive medicine was intended as part of these programs, the concept of prevention received strong endorsement in the renewal legislation passed in 1970 toward the close of the Ninety-first Congress. The new law, P. L. 91-515, also adds kidney disease as a categorical emphasis and brings in required participation by the Veterans Administration.

As the Program developed in California, the emphasis was very heavily in favor of categorical interests, and concentrated principally on achieving the desired improvements in health manpower and facilities through regional cooperative arrangements among existing professional and institutional resources, and continuing education. When the recommended national priorities for health were published in the spring of 1970 by the Department of Health, Education and Welfare (DHEW) there emerged a concerted effort to change the general direction of the Program. The emphasis on improving quality of medical services was considerably relaxed, and even to

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some extent discouraged, and the emphasis on improving the quantity of care was greatly increased.

As the Administration prepared to introduce its bill to extend Regional Medical Programs, national leaders began to speak favorably of developing "primary care" in areas where available medical and health services were insufficient to meet local needs. Had the proposed Administration bill passed, it would have eliminated the categorical emphasis of RMP, turning instead toward creation of new health care services and deleting the prohibition against interfering with existing patterns of patient care. Although the new legislation in its final version continued the categorical emphasis with the addition of kidney disease and retained the proscription against interfering with patterns of patient care, leaders in both DHEW and the Office of Management and Budget have recently emphasized the need for the Program to promote "new patterns of medical care" and to engage in the development of new and innovative levels of manpower. They particularly discuss the physician's assistant concept.

Spokesmen for the Administration have also emphasized that RMP should engage in the task of obtaining physician acceptance of the new forms of delivery and should help develop the training programs that would make new levels possible. One of these officials posed this question to the Program: "Is [RMP] providing a vehicle for physician acceptance of new forms of medical practice, such as prepaid group practice or improved referral patterns that may lead to higher quality or less expensive care?" This comment, from a White House aide in the Office of Management and Budget, appeared to some observers to be more of an instruction than a question, and is the only recent context in which the term "higher quality" has appeared. The conclusion seems inescapable: the original purposes of the Program have been altered.

This alteration has unsettled or disturbed some in the Program, both on staff and voluntary levels. Since the planning for operational projects requires a fairly long time, the projects on which planning begins on one day may be inappropriate for the priorities that exist on the day the planning has been completed. And those who

may have joined the Program on a voluntary basis in the beginning, and who have a deep interest in one of the categorical pursuits, may not find the Program to their liking with the implied change in emphasis.

One result is that the Program has had a certain amount of turnover in voluntary participation. In the beginning it attracted those who were deeply interested in the quality of medical care and in the categorical approach to improved health services. Later the Program attracted persons more interested in developing a greater quantity of care, especially for those areas without it today. This change in program direction also required a change in the stated objectives of the California Region.

But there have been other perhaps more subtle influences on RMP program development. The Program began with the expectation that it would eventually be funded at levels as high as \$500 million annually. In view of this expectation, many Regions began to develop plans for an over-all Program that would reflect this level of funding. Core staffs were recruited and began extensive planning pointed toward \$500 million funding levels in the third or fourth year of the Program. This accelerated planning pace could not possibly be rationally maintained when it became clear that available funding support was not expected to be even as much as one-quarter of the originally anticipated amount.

Since RMP effectiveness is built upon voluntary relationships, this unfulfilled commitment also had a retarding effect on the level of participation and enthusiasm as the months wore on. Many volunteers who had been extremely active in the beginning became disenchanted with the slow pace of funding, or the lack of funding, for the projects they had helped to develop. Some withdrew from RMP involvement altogether, or turned to other activities promising less frustration. The uncertainties of Federal funding had a deleterious effect on RMP core staffs as well. Some Areas in California were unable to stabilize their staffs, leading to uneven development in the cooperative arrangements necessary for a dynamic and successful Program. As a result, some Areas moved faster in developing proposals to meet the needs expressed locally; while others developed more slowly. In the long term this substantial cutback in the expected funding levels for RMP may have been the most damaging

development in terms of progress and success for the Program.

During the earliest meetings of RMP in California, it became apparent that strong feelings of territorial imperatives existed within each Area. Since each Area had been assigned a geographic territory for planning, and since the Area offices were administratively based within the structure of California's eight medical schools, it was natural that there would be healthy competition among the Areas. To a certain extent these feelings were expressed in the process of establishing objectives and goals to meet local needs. But the most prolonged examination of this sensitive subject came at meetings of the California Committee on Regional Medical Programs, particularly when the CCRMP was considering proposals for operational activities. The project review process was clumsy and inequitable and satisfied few. This was perhaps the natural result of a body of so diverse a nature, newly created, trying to gain an understanding of its responsibilities among unfamiliar or unsettling surroundings. The law was a new kind of social legislation. Several of the members of the CCRMP were strangers at first. And certainly most of the members had never sat on a committee where laymen would review medical matters. After two years a special subcommittee was established to review the organization and procedures of the CCRMP. A detailed series of recommendations to improve the technical review of project proposals was developed and finally adopted in October, 1970. The review mechanism now in effect has been thoroughly tested, is well understood throughout the Region, and appears to be well accepted. It has been highly praised nationally.

Establishment of objectives for the California Region also took many months and reflected some of the stress that grew out of the competitive feelings between Areas and between Areas and the Region. The objectives finally agreed upon have enjoyed an unusually high level of input from the voluntary associations, the professions and others interested in the Program. Because of the changing direction of RMP nationally, California has developed two sets of objectives. The first set follows the original intent of the Program, describing concepts and activities intended to lead toward an improved quality of medical and health services, along categorical lines. The second set of California RMP objec-

tives reflects the more recently announced national health priorities, emphasizing more the quantity of services, the development of different levels of manpower and the improvement of the organization and delivery of medical care. Stated another way, the original objectives apply to continuing education for existing health team professionals and for innovation, development and testing of delivery systems of health care or training programs, all extending over a period of years. The newer list of objectives is more modest in cost and scope, intended for shorter projects, in a framework within which demonstration or feasibility projects may be attempted to stimulate change in the organization and delivery of health services, particularly health services for the poor. Although they represent a more modest approach at this time, it would appear that they forecast the dominant course of the Program in the immediate future.

The newer objectives have been agreed upon by the California Committee on Regional Medical Programs in preparation for administrative changes expected to be established for California by the Regional Medical Programs Service of DHEW. The Administration has announced its intent to decentralize as much of the grant-making powers as possible. As part of this move, a limited number of RMP regions which have demonstrated administrative and fiscal management skills, and carry on program activity thought to be worthy of strong support, will be placed on an anniversary review basis. This will mean that requests for operational support funds will be made only once a year, and that the RMP regional advisory group (in California's case the CCRMP) will have greater responsibility for the management and the effective redirecting of available RMP funds within the Region. As part of the anniversary review concept, a developmental component will be awarded for short-term experimental or innovative activities that can be considered and begun after a very brief review period.

The second and more recent set of objectives for California was established for the developmental component. These objectives have two main priorities of equal importance. The first is to stimulate efforts to improve and increase the health manpower pool, focusing on professional,

sub-professional and para-professional personnel. The second is to stimulate change in the organization and delivery of health services, particularly for the urban poor, stressing preventive measures, prepaid group practice, use of sub-professional and para-professional personnel, ambulatory care services and neighborhood care delivery units. Other goals and target groups in the second priority category include improved coordination of Federal, State and local efforts to benefit migrant farm worker families, Indians and children during the first five years of life, and provision of adequate family planning services by 1975 to women of childbearing age who cannot at present obtain or do not have knowledge of such services. Projects of this short-term nature should stimulate the development of proposals for much larger scale efforts to serve the national priorities. Built into these long-term, large-scale efforts should be the eventual reliance on the sources of health care funding traditionally available to communities.

While Federal funding levels have been a disappointment to many, there have been several instances where alternate sources of financial support have been developed as a result of the original stimulus for planning under RMP leadership. Since it does appear that the Administration intends to follow the concept of level funding for Regional Medical Programs during the immediate years ahead, the use of RMP staff time to seek alternate sources of funding will become more important than it has been in the past. A substantial amount of effort is expected to be directed by RMP toward such catalytic activity.

One more indication of change in RMP pro-

gram development is becoming more apparent. In the Fall of 1969 there was the first organized attempt to bring together representatives of RMP offices and Comprehensive Health Planning representatives for the purpose of discussing issues of common interest. From this meeting there developed a more formal effort to define ways in which the two programs could work more closely together. The legislative mandate for Comprehensive Health Planning is far broader than it is for RMP, and the CHP offices throughout the State will be heavily burdened during the coming months with health facilities planning, largely because of California Law A.B. 1341. It has been proposed therefore that RMP assume as much as possible of the CHP responsibility for personal health services and manpower planning. This proposal is being developed with understanding and agreeable relationships among RMP and A and B agency* representatives of Comprehensive Health Planning. The California Committee on Regional Medical Programs has asked the State Health Planning Council to designate an official representative to be a member of CCRMP, to speak for A agency interests, and is also seeking an official B agency representative. The two programs appear to be meshing with a realistic appreciation of the responsibilities inherent in each. Meanwhile, RMP in California is also seeking similarly productive arrangements with Model Cities, Office of Economic Opportunity, Migrant Health and local and county programs and activities in health.

*A Agency—Based on Section 314(a) which authorizes in each state a health planning agency to carry out Public Law 89-749. The A Agency in California is the State Department of Public Health. B Agency—Based on Section 314(b) which decrees establishment of area-wide health planning agencies. There are nine authorized B agencies in California.